		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027680

Facility Name: Sheridan Health Care Center

Address: 2534 Elim Avenue (Number) Zion (City) 60099 (Zip Code)

County: Lake

Telephone Number: (847) 746-8435 **Fax #** (847) 746-1744

IDPA ID Number: 363194993001

Date of Initial License for Current Owners: 10/10/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust	X	Partnership		County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Garry S. Chankin, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3	174	Intermediate (ICF)	174	63,510	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	270	TOTALS	270	98,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	298		4,857	5,155	8
9	SNF/PED					9
10	ICF	67,304	5,792	1,807	74,903	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,602	5,792	6,664	80,058	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.24%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
MEALS ON WHEELS, ADULT DAY CARE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 4,133

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	334,868	64,385	12,640	411,893		411,893		411,893			1
2	Food Purchase		392,616		392,616		392,616	(284)	392,332			2
3	Housekeeping	314,752	73,888		388,640		388,640		388,640			3
4	Laundry	160,294	52,097	4,297	216,688		216,688		216,688			4
5	Heat and Other Utilities			250,597	250,597		250,597		250,597			5
6	Maintenance	241,288	29,606	86,189	357,083		357,083	(8,854)	348,229			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,051,202	612,592	353,723	2,017,517		2,017,517	(9,138)	2,008,379			8
	B. Health Care and Programs											
9	Medical Director			24,500	24,500		24,500		24,500			9
10	Nursing and Medical Records	2,967,377	182,368	6,358	3,156,103		3,156,103	(6,810)	3,149,293			10
10a	Therapy	85,857	3,905	26,639	116,401		116,401		116,401			10a
11	Activities	134,167	24,619	852	159,638		159,638		159,638			11
12	Social Services	452,302	3,290	5,385	460,977		460,977		460,977			12
13	Nurse Aide Training	6,052		3,846	9,898		9,898		9,898			13
14	Program Transportation			5,738	5,738		5,738		5,738			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,645,755	214,182	73,318	3,933,255		3,933,255	(6,810)	3,926,445			16
	C. General Administration											
17	Administrative	161,887		433,120	595,007		595,007	(382,126)	212,881			17
18	Directors Fees											18
19	Professional Services			82,886	82,886		82,886		82,886			19
20	Dues, Fees, Subscriptions & Promotions			90,625	90,625		90,625	(56,661)	33,964			20
21	Clerical & General Office Expenses	183,727	6,227	232,713	422,667		422,667	(103,841)	318,826			21
22	Employee Benefits & Payroll Taxes			727,647	727,647		727,647	(2,321)	725,326			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,439	5,439		5,439	(768)	4,671			24
25	Other Admin. Staff Transportation			1,029	1,029		1,029	(381)	648			25
26	Insurance-Prop.Liab.Malpractice			157,144	157,144		157,144		157,144			26
27	Other (specify):*							3,780	3,780			27
28	**TOTAL General Administration**	345,614	6,227	1,730,603	2,082,444		2,082,444	(542,318)	1,540,126			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,042,571	833,001	2,157,644	8,033,216		8,033,216	(558,266)	7,474,950			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Health Care Center #0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			389,074	389,074		389,074	(12,033)	377,041			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			259,619	259,619		259,619	(36,685)	222,934			32
33	Real Estate Taxes			221,829	221,829		221,829		221,829			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,897	32,897		32,897		32,897			35
36	Other (specify):*			8,497	8,497		8,497	(8,497)				36
37	**TOTAL Ownership**			911,916	911,916		911,916	(57,215)	854,701			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		309,494	306,395	615,889		615,889		615,889			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,595	7,595		7,595	(7,595)				41
42	Provider Participation Fee			147,825	147,825		147,825		147,825			42
43	Other (specify):*	152,034		4,679	156,713		156,713	(156,723)	(10)			43
44	**TOTAL Special Cost Centers**	152,034	309,494	466,494	928,022		928,022	(164,318)	763,704			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,194,605	1,142,495	3,536,054	9,873,154		9,873,154	(779,799)	9,093,355			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,079)	30		9
10	Interest and Other Investment Income	(36,685)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,935)	20		20
21	Owner or Key-Man Insurance	(2,321)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,419)	21		24
25	Fund Raising, Advertising and Promotional	(31,679)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(422)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,732)	20		28
29	Other-Attach Schedule	(194,897)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (401,453)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(378,346)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (378,346)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (779,799)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sheridan Health Care Center

ID# 0027680

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME (AMOUNT OF EXPENSE)	$ (7,595)	41	1
2	COST OF ADULT DAY CARE	(3,593)	43	2
3	SALARY-ADULT DAY CARE	(109,800)	43	3
4	ALZHEIMER DAY EXPENSE	(1,096)	43	4
5	VETERANS LAB EXPENSE	(1,179)	10	5
6	VETERANS PHYSICIAN EXPENSE	(5,631)	10	6
7	AMORTIZATION	(8,497)	36	7
8	CAPITALIZED R&M	(8,854)	06	8
9	BANK FEES	(350)	20	9
10	NON-ALLOWABLE SEMINAR	(768)	24	10
11	NON-ALLOWABLE TRAVEL	(301)	25	11
12	MARKETING SALARY	(42,234)	43	12
13	COPE DUES - ICLTC	(3,965)	20	13
14	NON-CARE ASSET DEPRECIATION	(954)	30	14
15				15
16				16
17				17
18				18
19				19
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21				21
22				22
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94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	**Total**	(194,897)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(284)											(284)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(8,854)											(8,854)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(9,138)											(9,138)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,810)											(6,810)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(6,810)											(6,810)	16
	C. General Administration													
17	Administrative			(219,543)	11,000	(79,647)	(93,936)						(382,126)	17
18	Directors Fees													18
19	Professional Services													19
20	Fees, Subscriptions & Promotions	(56,661)											(56,661)	20
21	Clerical & General Office Expenses	(103,841)											(103,841)	21
22	Employee Benefits & Payroll Taxes	(2,321)											(2,321)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(768)											(768)	24
25	Other Admin. Staff Transportation	(381)											(381)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			1,698		1,672	410						3,780	27
28	**TOTAL General Administration**	(163,972)		(217,845)	11,000	(77,975)	(93,526)						(542,318)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(179,920)		(217,845)	11,000	(77,975)	(93,526)						(558,266)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(12,033)											(12,033)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(36,685)											(36,685)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(8,497)											(8,497)	36
37	**TOTAL Ownership**	(57,215)											(57,215)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(7,595)											(7,595)	41
42	Provider Participation Fee													42
43	Other (specify):*	(156,723)											(156,723)	43
44	**TOTAL Special Cost Centers**	(164,318)											(164,318)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(401,453)		(217,845)	11,000	(77,975)	(93,526)						(779,799)	45

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 21,569	$ 21,569	15
16	V	27	PAYROLL TAXES		PRO HEALTH CARE, INC.		1,698	1,698	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MNGMNT. FEES - PRO HEALTH	116,992				(116,992)	23
24	V	17	MNGMNT. FEES - PRO HEALTH	124,120				(124,120)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 241,112			$ 23,267	$ * (217,845)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 309,000	SHA, LTD.	100.00%	$	$ (309,000)	15
16	V	17	M. FEES - FINN CONS.		SHA, LTD.		101,504	101,504	16
17	V	17	M. FEES - PRO HEALTH		SHA, LTD.		116,992	116,992	17
18	V	17	M. FEES - SHABAT & ASSOC.		SHA, LTD.		101,504	101,504	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 309,000			$ 320,000	$ * 11,000	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - J. FINN	$	FINN CONSULTING, INC.	100.00%	$ 21,857	$ 21,857	15
16	V	27	PAYROLL TAXES				1,672	1,672	16
17	V								17
18	V	17	MANAGEMENT FEES	101,504				(101,504)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 101,504			$ 23,529	$ * (77,975)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - RON SHABAT	$	SHABAT & ASSOCIATES	100.00%	$ 7,568	$ 7,568	15
16	V	27	PAYROLL TAXES				410	410	16
17	V								17
18	V	17	MANAGEMENT FEES	101,504				(101,504)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 101,504			$ 7,978	$ * (93,526)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Stanton Aron	Partner	Management	16.31%	See Attached	22.00	33.80%	Allocated	$ 21,569	17-7	1
2	Jack Finn	Partner	Mgmt. Cons.	9.32%	See Attached	17.00	48.50%	Allocated	21,857	17-7	2
3	Ron Shabat	Partner	Mgmt. Cons.	15.04%	See Attached	2.00	5.40%	Allocated	7,568	17-7	3
4	Nanjean Painter	Partner	Management	1.75%	See Attached	40.00	80.00%	Salary	129,350	12-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 180,344		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	$ 50,000	$ 50,000	22	$ 21,569	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	3,935		22	1,698	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 53,935	$ 50,000		$ 23,267	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHA, LTD. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	M. FEES - FINN CONS.	DIRECT ALLOCATION	1	1	101,504		1	101,504	1
2	17	M. FEES - PRO HEALTH	DIRECT ALLOCATION	1	1	116,992		1	116,992	2
3	17	M. FEES - SHABAT & ASSOC.	DIRECT ALLOCATION	1	1	101,504		1	101,504	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,000	$		$ 320,000	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FINN CONSULTING INC.
Street Address: 2901 W. COYLE
City / State / Zip Code: CHICAGO, IL 60645
Phone Number: ((773)764-3466
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - J. FINN	AVG. HOURS WORKED	35	2	$ 45,000	$ 45,000	17	21,857	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	35	2	3,443		17	1,672	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 48,443	$ 45,000		$ 23,529	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)982-1195
Fax Number: ((847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	AVG. HOURS WORKED	37	11	140,000	140,000	2	7,568	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	37	11	7,590		2	410	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 147,590	$ 140,000		$ 7,978	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MANUFACTURERS BANK		X	MORTGAGE	$46,648.00	9/28/98	$ 4,500,000	$ 3,015,281	9/2008	7.40%	$ 226,204	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT	VARIOUS	7/10/94	1,700,000	760,000	7/10/05	5.00%	33,415	6
7	FIRST MIDWEST BANK		X	LINE OF CREDIT	VARIOUS	4/2003	129,500	149,485				7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$46,648.00		$ 6,329,500	$ 3,924,766			$ 259,619	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule										(36,685)	13
14	TOTAL Non-Facility Related						$	$			$ (36,685)	14
15	TOTALS (line 9+line14)						$ 6,329,500	$ 3,924,766			$ 222,934	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	INTEREST INCOME	X					$	$			$ (36,685)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(36,685)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	198,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	204,829	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,829	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	215,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	221,829	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	146,210	8
	1999	150,301	9
	2000	160,170	10
	2001	188,807	11
	2002	204,829	12

ACCRUAL = 204829 X 1.04 = 215000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Health Care Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-22-301-007	LONG TERM CARE	$ 196,417.00	$ 196,417.00
2.	04-22-301-009	LONG TERM CARE	$ 8,412.00	$ 8,412.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 204,829.00	$ 204,829.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Health Care Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,793 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ADULT DAY CARE - 760 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	50,091	1990	$ 28,460	1
2					2
3	TOTALS	50,091		$ 28,460	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	270			1990	$ 5,384,307	$ 170,930		$ 153,837	$ (17,093)	$ 2,140,898	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,655		20	-		5,655	9
10	Various			1981	13,906		20	-		13,906	10
11	Various			1982	1,171		20	-		1,171	11
12	Various			1983	17,000		20	-		16,819	12
13	Various			1984	36,737		20	-		36,737	13
14	Various			1985	135,882		20	5,825	5,825	131,067	14
15	Various			1986	63,852		20	3,361	3,361	58,818	15
16	Various			1987	60,439		20	3,021	3,021	50,068	16
17	Various			1988	24,257		20	1,212	1,212	18,786	17
18	Various			1989	102,083		20	5,420	5,420	89,615	18
19	Various			1990	84,998		20	4,250	4,250	58,647	19
20	Various			1991	10,496		20	526	526	6,728	20
21	Various			1992	18,109		20	889	889	10,376	21
22	Various			1993	39,981		20	1,999	1,999	21,339	22
23	Various			1994	123,996		20	6,203	6,203	59,432	23
24	Various			1995	157,007		20	7,851	7,851	68,870	24
25	Various			1996	210,423		20	10,523	10,523	77,685	25
26	Various			1997	97,938		20	4,898	4,898	32,287	26
27	Various			1998	76,538		20	2,724	2,724	20,138	27
28	Various			1999	232,757		20	9,894	9,894	50,891	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			97,216			(97,216)		69
70	TOTAL (lines 4 thru 69)		$ 6,897,532	$ 268,146		$ 222,433	$ (45,713)	$ 2,969,933	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,897,532	$ 268,146		$ 222,433	$ (45,713)	$ 2,969,933	1
2	Fire Door 4Th Flr So	2000	4,038		20	202	202	808	2
3	Fire Door 4Thflr Nor	2000	4,038		20	202	202	808	3
4	Doors - Breakroom	2000	923		20	46	46	184	4
5	Down Payment - Walls	2000	5,550		20	278	278	1,089	5
6	Architect - Dementia	2000	752		20	38	38	149	6
7	Glass Alum Door	2000	800		20	40	40	157	7
8	Electrical Work	2000	1,440		20	72	72	288	8
9	Window/Light Fixture	2000	3,980		20	199	199	763	9
10	Main Dining Rm 4Thfl	2000	5,630		20	282	282	1,105	10
11	Architect - Dementia	2000	269		20	13	13	51	11
12	Chair Railing	2000	1,884		20	94	94	353	12
13	Handrails	2000	1,453		20	73	73	280	13
14	Electrical Sockets	2000	1,826		20	91	91	341	14
15	Doors - Rehab Dept	2000	600		20	30	30	113	15
16	Doors	2000	2,704		20	135	135	495	16
17	Wallpaper	2000	824		20	41	41	147	17
18	Wallpaper	2000	1,826		20	91	91	334	18
19	Piping	2000	4,552		20	228	228	836	19
20	Install Faucets	2000	3,925		20	196	196	702	20
21	Wallpaper	2000	1,988		20	99	99	355	21
22	Corner Guards	2000	652		20	33	33	118	22
23	Wallcovering	2000	153		20	8	8	28	23
24	Wallpaper	2000	1,000		20	50	50	175	24
25	Wallguard	2000	883		20	44	44	154	25
26	Fire Door	2000	4,130		20	207	207	707	26
27	Wallpaper	2000	666		20	33	33	113	27
28	Wallcovering	2000	632		20	32	32	112	28
29	Trac Lighting	2000	671		20	34	34	116	29
30	Window Treatments	2000	618		20	31	31	103	30
31	Metal Door	2000	1,010		20	51	51	170	31
32	Carpet	2000	1,354		20	68	68	227	32
33	Shades	2000	2,666		20	133	133	443	33
34	TOTAL (lines 1 thru 33)		$ 6,960,969	$ 268,146		$ 225,607	$ (42,539)	$ 2,981,757	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,960,969	$ 268,146		$ 225,607	$ (42,539)	$ 2,981,757	1
2	Fire Door	2000	4,137		20	207	207	673	2
3	Wall Guard	2000	636		20	32	32	104	3
4	Hinge/Lock/Deadbolt	2000	656		20	33	33	105	4
5	Tile	2000	703		20	35	35	105	5
6	Architect'S Fee	2000	573		20	29	29	87	6
7	Motor	2000	1,288		20	64	64	192	7
8	Generator Circuit	2000	1,159		20	58	58	174	8
9	Compressor Controls	2000	2,448		20	122	122	366	9
10	Temperature Controls	2000	2,666		20	133	133	399	10
11	Hot Water Boiler	2000	602		20	30	30	90	11
12	Chiller	2000	7,414		20	371	371	1,113	12
13	Alley Lights	2000	504		20	25	25	75	13
14	3Rd Flr Cornices	2000	598		20			598	14
15	Cubicle Curtains	2000	1,950		20	98	98	327	15
16	Fire Door & Install	2001	4,000		20	200	200	600	16
17	Door Replacement	2001	5,425		20	271	271	790	17
18	Cornices & Valances	2001	2,455		20	123	123	369	18
19	Window Treatment	2001	2,162		20	108	108	315	19
20	Wallcovering	2001	1,782		20	89	89	260	20
21	Wallcovering	2001	2,217		20	111	111	315	21
22	Remodeling	2001	8,000		20	400	400	1,100	22
23	Fire Panel	2001	605		20	30	30	83	23
24	Remodeling	2001	2,780		20	139	139	382	24
25	Fire Insulation	2001	546		20	27	27	72	25
26	Electric Circuit	2001	230		20	12	12	32	26
27	Remodeling/Drywall	2001	3,286		20	164	164	465	27
28	Fire Dampers	2001	9,779		20	489	489	1,304	28
29	Birch Doors	2001	2,616		20	131	131	338	29
30	Floors	2001	1,883		20	94	94	243	30
31	Wallpaper	2001	1,358		20	68	68	176	31
32	Refrigeration Lines	2001	10,203		20	510	510	1,318	32
33	Wooden Planters	2001	200		20	10	10	26	33
34	TOTAL (lines 1 thru 33)		$ 7,045,830	$ 268,146		$ 229,820	$ (38,326)	$ 2,994,353	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,045,830	$ 268,146		$ 229,820	$ (38,326)	$ 2,994,353	1
2	Refrigeration Lines	2001	10,204		20	510	510	1,318	2
3	Pull Station Protect	2001	1,163		20	58	58	150	3
4	Room Sign	2001	745		20	75	75	188	4
5	Handrail	2001	1,955		20	98	98	245	5
6	Electrical Circuits	2001	2,198		20	110	110	275	6
7	Refrigeration Lines	2001	4,689		20	234	234	585	7
8	Fire Damper	2001	616		20	31	31	78	8
9	Boiler	2001	743		20	37	37	93	9
10	Wallpaper	2001	4,243		20	212	212	495	10
11	Renovations	2001	1,900		20	95	95	214	11
12	Mosaic/Grout	2001	800		20	21	21	46	12
13	Upholsted Cornices	2001	769		20	38	38	86	13
14	Cement	2001	383		20	19	19	41	14
15	Solar Shades	2001	4,028		20	403	403	873	15
16	Roof Insulation	2001	5,950		20	298	298	646	16
17	Handrail/Vinyl Floor	2001	6,519		20	326	326	679	17
18	Wallpaper	2001	1,537		20	77	77	160	18
19	Reciprocal Chiiler	2001	4,576		20	229	229	477	19
20	Central Air Blower	2001	1,192		20	60	60	165	20
21	Fire Dampers	2001	9,103		20	455	455	1,251	21
22	Padding	2001	908		20	45	45	109	22
23	Apartment Compactor	2001	9,830		20	492	492	1,189	23
24	Wallpaper	2001	2,905		20	145	145	350	24
25	Drain Work	2001	1,794		20	179	179	374	25
26	Fire Dampers	2001	2,133		20	107	107	222	26
27	Coil Repairs	2001	1,605		20	80	80	167	27
28	Motor	2001	705		20	35	35	73	28
29	Landscaping	2001	925		20	46	46	96	29
30	Compressor Repairs	2001	4,255		20	213	213	443	30
31	Door Edges	2002	4,091		20	409	409	818	31
32	Amp Box	2002	802		20	80	80	160	32
33	Shades	2002	10,131		20	1,013	1,013	1,857	33
34	TOTAL (lines 1 thru 33)		$ 7,149,227	$ 268,146		$ 236,050	$ (32,096)	$ 3,008,276	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,149,227	$ 268,146		$ 236,050	$ (32,096)	$ 3,008,276	1
2	Doors	2002	861		20	86	86	158	2
3	Boiler	2002	7,883		20	657	657	1,204	3
4	Pergo Floor	2002	2,054		20	137	137	240	4
5	Generator	2002	8,200		20	1,171	1,171	1,952	5
6	Flooring	2002	449		20	30	30	50	6
7	Water Heater	2002	7,602		20	634	634	1,056	7
8	Door & Frame	2002	1,651		20	165	165	275	8
9	Compressor	2002	12,526		20	1,789	1,789	2,684	9
10	Medical Office	2002	44,200		20	4,420	4,420	6,630	10
11	Bathroom	2002	1,306		20	87	87	123	11
12	Architect Fee	2002	6,000		20	154	154	192	12
13	Cement Curb	2002	895		20	90	90	112	13
14	Landscaping/Curbs	2002	2,536		20	169	169	211	14
15	Burners	2002	8,395		20	420	420	525	15
16	Window Treatment	2002	944		20	94	94	181	16
17	Smoke Alarms	2002	792		20	113	113	179	17
18	Window Coverings	2002	3,477		20	348	348	406	18
19	Wallpaper Dining Room	2002	1,447		20			1,447	19
20	Wallpaper Resident Rooms	2002	3,053		20			3,053	20
21	Wallpaper Offices	2002	927		20	155	155	927	21
22	Wallpaper Breakrooms	2002	1,252		20	313	313	1,252	22
23	Wallpaper Office/Breakroom	2002	1,949		20	487	487	1,949	23
24	Painting	2002	4,000		20	3,333	3,333	4,000	24
25	Painting	2002	4,000		20	3,333	3,333	4,000	25
26	Wallpaper 3Rd Floor	2002	5,212		20	4,778	4,778	5,212	26
27	Floor Switch Repairs	2002	575		20	58	58	96	27
28	Heater Repairs	2002	758		20	76	76	120	28
29	Water Heater Repairs	2002	2,228		20	223	223	260	29
30	Pilot Safety Valve Install	2002	2,070		20	207	207	224	30
31	Elevator Repairs	2002	1,104		20	55	55	83	31
32	Elevator Repairs	2002	2,173		20	109	109	118	32
33	Boiler Repairs	2002	1,441		20	120	120	220	33
34	TOTAL (lines 1 thru 33)		$ 7,291,187	$ 268,146		$ 259,861	$ (8,285)	$ 3,047,415	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,291,187	$ 268,146		$ 259,861	$ (8,285)	$ 3,047,415	1
2	Crash Rail	2003	6,798		20	680	680	680	2
3	Handrail	2003	7,633		20	763	763	763	3
4	Platform	2003	1,386		20	139	139	139	4
5	Cove Base	2003	515		20	34	34	34	5
6	Carpeting	2003	29,162		20	3,472	3,472	3,472	6
7	Carpeting-Asbestos Removal	2003	1,905		20	227	227	227	7
8	Sprinkler Heads	2003	1,500		20	125	125	125	8
9	Remodel	2003	6,650		20	554	554	554	9
10	Electrical Work	2003	5,920		20	493	493	493	10
11	Ramp Training Set	2003	810		20	74	74	74	11
12	Electronic Key Override	2003	1,718		20	157	157	157	12
13	Office Rehab	2003	104,717		20	7,854	7,854	7,854	13
14	Wallpaper	2003	1,276		20	851	851	851	14
15	Wiring And Termination	2003	3,725		20	248	248	248	15
16	Signs	2003	512		20	38	38	38	16
17	Fire Dampers	2003	854		20	102	102	102	17
18	Alarm Detection System	2003	109,900		20	7,327	7,327	7,327	18
19	Doors	2003	1,269		20	42	42	42	19
20	Office Rehab	2003	12,134		20	809	809	809	20
21	Sprinkler	2003	700		20	35	35	35	21
22	Doors	2003	1,722		20	57	57	57	22
23	Flooring	2003	1,250		20	56	56	56	23
24	Wallpaper	2003	1,174		20	783	783	783	24
25	Wallpaper	2003	3,069		20	2,046	2,046	2,046	25
26	Handrail	2003	663		20	19	19	19	26
27	Nursing Station	2003	17,600		20	1,173	1,173	1,173	27
28	Chimney	2003	975		20	38	38	38	28
29	Doors	2003	385		20	15	15	15	29
30	Floors	2003	6,618		20	257	257	257	30
31	Door And Locks	2003	536		20	21	21	21	31
32	Fire Alarm	2003	1,510		20	108	108	108	32
33	Timer	2003	656		20	66	66	66	33
34	TOTAL (lines 1 thru 33)		$ 7,626,429	$ 268,146		$ 288,524	$ 20,378	$ 3,076,078	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,626,429	$ 268,146		$ 288,524	$ 20,378	$ 3,076,078	1
2	Alarm Detection Syst	2003	4,499		20	214	214	214	2
3	Door Frame	2003	1,750		20	29	29	29	3
4	Floor Tiles	2003	11,352		20	441	441	441	4
5	Vacuum Pump	2003	7,683		20	213	213	213	5
6	Aluminum Doors	2003	7,951		20	221	221	221	6
7	Roof	2003	34,512		20	3,099	3,099	3,099	7
8	Shades	2003	10,154		20	508	508	508	8
9	Alarm Detection	2003	1,000		20	36	36	36	9
10	Carpeting	2003	8,020		20	191	191	191	10
11	Blinds	2003	1,918		20	16	16	16	11
12	Fire Doors	2003	6,150		20	146	146	146	12
13	Boiler	2003	4,749		20	66	66	66	13
14	Elevator Alarm	2003	1,473		20	12	12	12	14
15	Tile	2003	1,053		20	23	23	23	15
16	Tile	2003	1,555		20	17	17	17	16
17	Tile	2003	3,623		20	81	81	81	17
18	Window Treatments	2003	3,199		20	53	53	53	18
19	Bulding Facade	2003	23,626		20	1,378	1,378	1,378	19
20	Boiler Repairs	2003	2,007		20				20
21	Boiler Repairs	2003	3,687		20				21
22	Roof Repairs	2003	578		20				22
23	Steam Table Repairs	2003	2,582		20				23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,550	$ 268,146		$ 295,268	$ 27,122	$ 3,082,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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50									50
51									51
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 796,125	$ 76,289	$ 73,368	$ (2,921)	10	$ 428,399	71
72	Current Year Purchases	70,896	43,685	8,405	(35,280)	10	8,405	72
73	Fully Depreciated Assets	495,232				10	495,232	73
74								74
75	TOTALS	$ 1,362,253	$ 119,974	$ 81,773	$ (38,201)		$ 932,036	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,160,263	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 388,120	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 377,041	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,079)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,014,858	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND - 1994	$ 199,000	$	$	86
87	REMODEL STORAGE ROOM - 1999	4,000	200		87
88	REMODEL STORAGE RM - 1999	10,000	500		88
89	REMODEL STORAGE ROOM - 1999	4,300	215		89
90	DAYCARE CTR ARCHITEC - 2000	787	39		90
91	TOTALS	$ 218,087	$ 954	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 19,937 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	DODGE VAN	$ 456.00	$ 5,011	17
18	ADMINISTRATIVE		640.00	7,950	18
19					19
20					20
21	TOTAL		$ 1,096	$ 12,961	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)	1,068	4,984		6,052
5	In-House Trainer Wages (c)	557	2,539		3,096
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	135	615		750
9	TOTALS	$ 1,760	$ 8,138	$	$ 9,898
10	SUM OF line 9, col. 1 and 2 (e)	$ 9,898			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	17

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 131,954	$		$ 131,954	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,607			9,607	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			148,748			148,748	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				257,566		257,566	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					16,086	51,928		68,014	13
14	TOTAL			$		$ 306,395	$ 309,494		$ 615,889	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 278,778	$	1
2	Cash-Patient Deposits	96,282		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,513,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	827,285		5
6	Prepaid Insurance	98,372		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	92,014		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,906,315	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	227,460		13
14	Buildings, at Historical Cost	5,384,307		14
15	Leasehold Improvements, at Historical Cost	2,207,135		15
16	Equipment, at Historical Cost	1,412,733		16
17	Accumulated Depreciation (book methods)	(4,201,437)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	40,361		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,070,559	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,976,874	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 358,142	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	106,091		28
29	Short-Term Notes Payable	909,484		29
30	Accrued Salaries Payable	61,130		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,609		31
32	Accrued Real Estate Taxes(Sch.IX-B)	215,000		32
33	Accrued Interest Payable	22,066		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,949		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,678,471	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,015,282		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,015,282	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,693,753	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,283,121	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,976,874	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,664,541	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,664,541	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(207,820)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(173,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (381,420)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,283,121	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,841,103	1
2	Discounts and Allowances for all Levels	(79,797)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,761,306	3
	B. Ancillary Revenue		
4	Day Care	47,813	4
5	Other Care for Outpatients		5
6	Therapy	578,292	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 626,105	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,853	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,132	19
20	Radiology and X-Ray		20
21	Other Medical Services	218,253	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 241,238	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,685	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,685	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,665,334	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,017,517	31
32	Health Care	3,933,255	32
33	General Administration	2,082,444	33
	B. Capital Expense		
34	Ownership	911,916	34
	C. Ancillary Expense		
35	Special Cost Centers	780,197	35
36	Provider Participation Fee	147,825	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,873,154	40
41	**Income before Income Taxes (line 30 minus line 40)****	(207,820)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (207,820)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,120	$ 61,552	$ 29.03	1
2	Assistant Director of Nursing	5,715	6,293	132,831	21.11	2
3	Registered Nurses	25,820	28,186	717,688	25.46	3
4	Licensed Practical Nurses	26,941	28,808	665,605	23.10	4
5	Nurse Aides & Orderlies	114,013	121,323	1,325,455	10.93	5
6	Nurse Aide Trainees	680	680	6,052	8.90	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,229	8,356	85,857	10.27	8
9	Activity Director					9
10	Activity Assistants	12,439	13,466	134,167	9.96	10
11	Social Service Workers	26,250	28,469	452,302	15.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,540	35,926	334,868	9.32	15
16	Dishwashers					16
17	Maintenance Workers	20,428	22,279	241,288	10.83	17
18	Housekeepers	32,794	35,825	314,752	8.79	18
19	Laundry	16,362	17,590	160,294	9.11	19
20	Administrator	2,080	2,456	114,470	46.61	20
21	Assistant Administrator	2,080	2,264	47,417	20.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,130	13,172	183,727	13.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,719	4,241	64,246	15.15	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,925	7,383	152,034	20.59	33
34	TOTAL (lines 1 - 33)	351,225	378,837	$ 5,194,605 *	$ 13.71	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 12,640	01-03	35
36	Medical Director	MONTHLY	24,500	09-03	36
37	Medical Records Consultant	MONTHLY	1,088	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	4,400	10-03	39
40	Physical Therapy Consultant	MONTHLY	9,200	10a-03	40
41	Occupational Therapy Consultant	MONTHLY	17,439	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	852	11-03	44
45	Social Service Consultant	MONTHLY	5,385	12-03	45
46	Other(specify)				46
47	URB CONSULTANT	MONTHLY	870	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 76,374		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARLA BENSON	ADMINISTRATOR	0	$ 114,470
ROSS ZELLER	ASST. ADMIN	0	47,417
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 161,887

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - SHA, LTD	$ 309,000
PRO HEALTH - ADMINISTRATIVE	124,120
TOTAL (agree to Schedule V, line 17, col. 3)	$ 433,120
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SLS	COMPUTER SUPPORT	$ 6,127
S. ELSTER	SOFTWARE SUPPORT	1,218
ACCU MED	SOFTWARE SUPPORT	4,050
A-TECH	COMPUTER SUPPORT	6,313
CAMDEN	NETWORK SUPPORT	500
PAYCHEX	DATA PROCESSING	10,224
BISYS	DATA PROCESSING	4,679
FR&R	ACCOUNTING	43,101
LANER, MUCHIN, DOMBROW	LEGAL	73
NEAL, GERBER & EISENBERG	LEGAL	1,762
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	4,839
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 82,886

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,434
Unemployment Compensation Insurance	35,509
FICA Taxes	387,360
Employee Health Insurance	85,445
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
UNION INSURANCE	61,212
EMPLOYEE BENEFITS	19,366
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,326

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,396
Advertising: Employee Recruitment	15,499
Health Care Worker Background Check	
(Indicate # of checks performed)	
DUES	545
DUES-ICLTC	11,169
LICENSES	2,355
ADVERTISING	44,410
Less: Public Relations Expense	( )
Non-allowable advertising	(31,678)
Yellow page advertising	(12,732)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,964

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,671
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,671

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $15134**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,740** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **147,825**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% LN 14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.